Eli's Rehab Report

Smart MDM Can Be Worth $35 A Pop

If you've been downcoding to a level-four office visit or lower just to play it safe, you may be missing out on some well-deserved reimbursement.

Facing CMS scrutiny of high-level office visit coding and complicated coding guidelines, many practices shy away from reporting 99215 for physician services to escape possible audits. You can avoid this problem by learning some clear-cut rules regarding criteria for high-level E/M visits. Assuming your physician's services adequately qualify for a higher-level E/M code, you could see a reimbursement difference of around $30 or $35 as you move up the scale from 99213 to 99215.

In October, we told you how to ensure that your his-tory levels made the cut for high-level E/M codes. Now, we'll concentrate on medical decision-making (MDM).

Established Patient E/M Level Takes 2 out of 3

You should use three components to determine the level of E/M service to report. These include the history taken at the time of visit, the extent of physical examination, and medical decision-making (MDM). For office or other outpatient visits for established patients, you must meet two of the three criteria in order to bill for a specific level of care. New patients require three out of the three criteria.

Most coders find the MDM piece of the puzzle difficult to fit into place. Determining the difference between straightforward (S), low (L), moderate (M), and high (H) MDM can be an arduous task. Select the MDM level by looking at three aspects of the visit:

1. number of diagnoses and/or management options
2. amount and/or complexity of medical records, diagnostic tests and/or other information that is obtained, reviewed and analyzed
3. risk of significant complications, morbidity and/or mortality including comorbidities associated with the patient's presenting problem(s), diagnostic procedure(s), and/or the possible management options

Risk Element Can Ensure Pay

Determining the level of risk can be the hardest of the three components, since it requires more than just counting diagnosis options or lab tests ordered. According to **Catherine Brink, CMM, CPC**, president of Healthcare Resource Management of Spring Lake, N.J., this category includes risks associated with the presenting problems, the diagnostic procedures, and the management options. The highest level of risk in any of these areas determines the overall risk.

Take the four levels of risk as examples:

4. Minimal - One minor problem. Diagnostic procedures include laboratory tests requiring venipuncture, x-rays, urinalysis or ultrasounds. Management options include rest and simple bandages.

5. Low - Two or more minor problems, one stable chronic illness, or an acute uncomplicated illness. Diagnostic procedures include superficial needle biopsies, laboratory tests requiring arterial puncture, noncardiovascular imaging studies such

as barium enema, and physiologic tests not under stress. Management options include over-the-counter drugs, minor surgery with no risk factors, therapy, and IV fluids without additives.

6. Moderate - One or more chronic illnesses with mild exacerbation, two or more stable chronic illnesses, an undiagnosed problem, acute illness with systematic symptoms, or an acute complicated injury. Diagnostic procedures include physiologic tests under stress, diagnostic endoscopies with no risk factors, deep needle or incisional biopsy, cardiovascular imaging studies with contrast and no risk factors, and obtaining fluid from the body. Management options include minor surgery with identified risk factors, elective major surgery with no risk factors, prescription-drug management, therapeutic nuclear medicine, and IV fluid with additives.

7. High - One or more chronic illnesses with severe exacerbation or progression, acute or chronic illnesses or injuries that may pose a threat to life or bodily function or an abrupt change in neurologic status. Diagnostic procedures include imaging studies with contrast and identified risk factors, cardiac electrophysiological tests, and diagnostic endoscopies with risk factors.

   Management options include elective major surgery with risk factors, emergency major surgery, parenteral-controlled substances, drug therapy requiring intensive monitoring for toxicity, and the decision not to resuscitate or to de-escalate care because of poor prognosis.

   Add Diagnostic Options to the Mix

   Although determining the level of risk may be the most difficult for you, the number of diagnoses and treatment options should not be overlooked. According to CMS guidelines, the number of possible diagnoses and management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis, and the management decisions made by the physician.
   You must document an assessment, clinical impression, or diagnosis for each encounter, along with the initiation or change in treatment and any consultations or referrals initiated. For a presenting problem with an established diagnosis, document whether the problem is
   (1) improved, well controlled, resolving, or resolved or
   (2) inadequately controlled, worsening, or failing to change as expected. You can use the number and types of diagnostic tests employed as an indicator of the number of possible diagnoses.

   Document Complexity of Data

   The physician needs to document the tests performed, tests reviewed, and past medical records reviewed, Brink says. If it is not documented, you cannot count it toward the complexity-of-data category of MDM. According to CMS, the amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered and reviewed. The decision to obtain and review old medical records and the discussion of test results with the physician who performed or interpreted the tests are also indicators of the complexity of data to be reviewed.

   Clear Up Confusion With Case Studies

   Considering the myriad information you have to assimilate to determine the level of MDM, you should take a look at the following examples provided by **Raequell Duran**, president of Practice Solutions based in Santa Barbara, Calif:

8. Scenario #1: Straightforward MDM. The patient has one self-limited or minor problem such as an ankle sprain that requires no testing and no treatment.

9. Scenario #2: Low-Complexity MDM. The patient has one stable, chronic illness, such as sciatica, which is responding well to prescribed exercises and requires only over-the-counter NSAIDs.

10. Scenario #3: Moderate MDM. The patient has a condition, such as arthritis, that requires prescription-drug management.

11. Scenario #4: High MDM. The physiatrist sees the patient for an acute or chronic illness or injury that poses a threat to life or bodily function, such as multiple sclerosis, and performs invasive diagnostic procedures, such as spinal fluid testing. He also refers the patient or decides to perform an emergency major surgery.

    It is important to remember that the examples above represent only one portion of medical decision-making: overall risk. The number of presenting problems and data reviewed must be determined along with the overall risk to determine the type of MDM. (The above examples are not intended to be vignettes and are not approved or sanctioned by Medicare or the AMA.)